

## Care Coordination Form

Please use this form to tell us how we can better help your patient. You may securely return it to us by fax at 1-866-247-1150.

To: \_\_\_\_\_  
Attn: \_\_\_\_\_  
Fax: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Patient Name: \_\_\_\_\_  
Patient ID/DOB: \_\_\_\_\_

Date: \_\_\_\_\_  
Number of pages, including cover sheet \_\_\_\_\_  
From: \_\_\_\_\_  
Fax: \_\_\_\_\_  
Phone: \_\_\_\_\_

### Education of patient/caregiver

- |   |  |
|---|--|
| <input type="checkbox"/> Nutrition/Diet     | <input type="checkbox"/> Comorbidity: List _____           |
| <input type="checkbox"/> Exercise           | <input type="checkbox"/> Complication: List _____          |
| <input type="checkbox"/> Safety Precautions | <input type="checkbox"/> Patient specific risk: List _____ |
| <input type="checkbox"/> Disease Process    | <input type="checkbox"/> Other _____                       |

### Skills Development/Self Management

- |  |  |
|--|--|
| <input type="checkbox"/> Self infusion skills                              | <input type="checkbox"/> Blood pressure monitoring _____ |
| <input type="checkbox"/> Home safety/Falls prevention                      | <input type="checkbox"/> DME Training: _____             |
| <input type="checkbox"/> Monitor for sentinel symptoms List symptoms _____ |  |
| <input type="checkbox"/> Other _____                                       | <input type="checkbox"/> Skin care _____                 |

### Compliance

- Compliance with medication, treatment plan or other items. List specific issues:  
\_\_\_\_\_

### Coordination of Services and Support

- Assist patient with appointment or benefits coordination     Medication access     Transportation  
 Identify community-based support services

Issues: \_\_\_\_\_

- Assist with coordinating authorized services (specify)

\_\_\_ RN/Home Care Services

\_\_\_ Physical Therapy

\_\_\_ Occupational Therapy

\_\_\_ Speech Therapy

\_\_\_ Durable Medical Equipment

\_\_\_ Resource Specialist Services

\_\_\_ Support Services: List \_\_\_\_\_

\_\_\_ Other: List \_\_\_\_\_

### Follow Up

- After office visit     After hospital discharge     Call me to discuss patient's care     Other

List key issues: \_\_\_\_\_

### Preferred Method of Communication

Urgent:  Phone     Pager \_\_\_\_\_     E-mail \_\_\_\_\_

Routine:  Phone     Mail     Fax     E-mail \_\_\_\_\_

Comments: \_\_\_\_\_

**WARNING:** This message is intended only for the use of the individual or entity to which it is addressed, and may contain information that is privileged, confidential and exempt from disclosure under applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone at the number above. This fax has been sent from a secure location that meets the requirements of HIPAA and other applicable regulations. Returned fax transmissions will be received with an equal level of compliance. Member privacy is important to us. Our employees are trained regarding the appropriate way to handle our plan members' private health information. Thank You.